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Outcomes for Physicians With Opioid Dependence Treated Without Agonist Pharmacotherapy in Physician Health Programs

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ABSTRACT

Aims: To compare treatment outcome among substance dependent physicians enrolled in a physician health program (PHP) who have a history of alcohol use only, any opioid use, or non-opioid drug use, in order to determine whether the distinctive PHP system of care management is as effective for individuals with opioid use disorders as for those with alcohol or other drug use disorders.
Methods: A 5-year, retrospective chart review, intent-to-treat analysis was conducted for all physicians admitted to 16 physician health programs (N = 702; 85.5% male; age range = 24–75). Analyses compared treatment outcomes for participants based upon their substance(s) of abuse [i.e., 1) "Alcohol Only" (n = 204), 2) "Any Opioid" with or without alcohol use (n = 339), and 3) "Non-Opioid" drug use with or without alcohol use (n = 159)].
Results: In this sample, 75–80% of physicians across the three groups never tested positive for alcohol or drugs during their extended care management period with random drug testing. This included physicians with opioid dependence who did not receive opioid substitution therapy (OST). Of the 22.1% of physicians who had a positive test, two thirds (i.e., 14.5% of the total sample) had just one positive test, and only one third (i.e., 7.6% of the total sample) had more than one positive test. These results were similar in all three groups.
Conclusions: These results indicate that individuals with opioid use disorders who are managed by PHPs can achieve long-term abstinence from opioids, alcohol, and other drugs without OST through participation in abstinence-based psychosocial treatment with extended, intensive care management following discharge.

1. Introduction

The goal of abstinence-based psychosocial treatment (ABPT) is lifetime abstinence from all addictive substances. Participation in intensive (i.e., 30–90 days) ABPT typically consists of residential or partial-hospitalization level treatment involving individual and group psychotherapy (frequently based in cognitive–behavioral theory), process groups, family therapy, recreational therapy, educational programming, and introduction to the 12-step program and philosophy. It is considered efficacious in promoting early abstinence among individuals with substance use disorders (Condelli & Hubbard, 1994; Darke et al., 2005; Moos, Pettit, & Gruber, 1995). After completing ABPT, patients are encouraged to actively participate in 12-step (e.g., Alcoholics Anonymous or Narcotics Anonymous) meetings or other community-based recovery support for the long-term. However, patients with opioid dependence are often cautioned against ABPT, due to studies demonstrating worse outcomes for those participating in ABPT compared to opioid substitution therapy (OST) with methadone or buprenorphine. For example, World Health Organization guidelines for treatment of opioid dependence note that OST increases treatment retention, reduces heroin use, and produces lower mortality rates than ABPT alone (World Health Organization, 2009). A separate review of 11 studies concluded that OST reduces heroin use better than treatments that do not include OST. However, authors noted that heroin users frequently withdrew from trial studies when assigned to a drug-free program, resulting in a lack of adequate comparison (Mattick, Breen, Kimber, & Davoli, 2009).

Methadone maintenance treatment is considered efficacious when administered at adequate dosing (D'Aunno & Pollack, 2002; D'Aunno & Vaughn, 1992; Pollack & D'Aunno, 2008; Strain, Bigelow, Liebson, & Stitzer, 1999) in outpatient clinics with counseling, and subject to contingency management through random drug testing (Calsyn & Saxon, 1987; McLellan, Arndt, Metzger, Woody, & O'Brien, 1993). Though benefits often do not persist when methadone is discontinued, methadone is generally regarded as the most effective treatment for opioid dependence (Van Den Brink & Haasen, 2006; Zador, 2007)

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because of documented reductions in opioid use, improvements in retention, and decreased drug-related risk behaviors (Ball & Ross, 1991; Sees et al., 2000). Buprenorphine demonstrates similar benefits, with reduced opioid use and improved treatment retention (Fudala et al., 2003; Mattick, Breen, Kimber, & Davoli, 2014), including for prescription opioid dependence (Weiss et al., 2011). Like methadone, response during buprenorphine treatment depends upon adequate dosing (Fareed, Vayalapalli, Casarella, & Drexler, 2012; Mattick et al., 2014), though it may be less effective than methadone as a maintenance treatment (Mattick et al., 2014). One significant benefit to buprenorphine is that it is commonly administered as a buprenorphine/naloxone compound to discourage abuse or overdose. Buprenorphine is associated with low risk of fatality or other negative outcomes during treatment (Apelt, Scherbaum, Gölz, Backmund, & Soyka, 2013). Indeed, the data clearly demonstrate that OST reduces fatal overdoses among individuals who are actively participating in OST programs (Connery, 2015).

However, there remain several concerns regarding the efficacy of OST. Among them, patients being treated often continue illicit opioid use and other illicit drug and/or alcohol use (Fiellin et al., 2011) and treatment drop-out is common (Clausen, Anchersen, & Waal, 2008; Fiellin et al., 2011; Stein, Cloe, & Friedmann, 2005). In addition, treatment with OST is often recommended for life due to the inherent risks of attempting to taper to zero dose (Calsyn, Malcy, & Saxon, 2006); whereas, the idea of lifelong OST is undesirable for many patients, and may be incompatible with maintaining their employment in certain safety-sensitive careers (e.g., healthcare professional, airline pilot, law enforcement officer) due to licensure restrictions or other regulations.

A few studies have demonstrated the potential for positive outcome among individuals with opioid dependence who do not receive OST. For example, a study of individuals entering treatment for heroin dependence showed substantial reductions in heroin and other drug use at 1-year follow-up across three distinct treatment conditions. Sixty-five percent (65%) of patients in methadone/buprenorphine maintenance therapy, 52% in detoxification, and 63% in abstinence-based residential rehabilitation were heroin-free. Only 25% of a small sample of heroin users not seeking treatment was heroin-free after 1 year (Teesson et al., 2006). Further, in 2014, a series of studies assessing treatment outcome for emerging adults (aged 18–24) with opioid dependence (including both heroin and prescription opioids) demonstrated similar outcomes for patients treated in a 28-day abstinence-based residential program [42.5% abstinent at 6-month follow-up (Schuman-Olivier, Weiss, Hoeppner, Borodovsky, & Albanese, 2014)] compared to those treated with buprenorphine plus intensive outpatient addiction treatment [38% treatment retention (Schuman-Olivier et al., 2014)].

Thus, more research is needed regarding the relative efficacy of ABPT for patients with opioid dependence, particularly within populations that may be unable to benefit from OST. With this goal in mind, the present study examined treatment outcome within a cohort of physicians with substance dependence who underwent a specialized form of ABPT plus monitoring by their state physician health program (PHP). The features of this treatment approach are more fully described elsewhere (DuPont, McLellan, Carr, Gendel, & Skipper, 2009). Because each PHP is independent, the process can vary between states. This makes for a less than optimal independent variable for conducting research; however, the general concepts applied by all state PHPs are consistent and include: 1) thorough evaluation for each participant to establish diagnosis(es); 2) individualized primary treatment to address all the individual's most acute problems; and, 3) referral back to the PHP to sign a long-term monitoring contract that includes standard and customized recommendations for ongoing treatment and monitoring.

Though many opioid-dependent physicians use agonist therapy during detoxification, most who are reported to their licensing board or referred to a PHP due to substance-related impairment may not return to work while using OST. The PHPs typically have informal policies disallowing OST for practicing physicians due to the safety-sensitive nature of physicians' work and lack of data demonstrating whether long-term use of opioid medication may impact their performance. In some cases, physicians are allowed to work while using OST, but typically not in positions where precision and accuracy are paramount (e.g., a practicing surgeon is unlikely to be approved for OST).

As a result, there is strong motivation to pursue a goal of total abstinence among this population. Physicians enrolled in a PHP typically undergo relatively brief (i.e., 30–90 days) formal ABPT with concurrent treatment for comorbid mental health disorders. This is typically followed by 5 years of mandatory monitoring for drugs and alcohol with random urine, oral fluid, and/or hair testing (Teesson et al., 2006). Monitoring for physicians with comorbid psychiatric conditions may include the PHP receiving regular reports from the treating psychiatrist and/or psychotherapist regarding the physician's current mental health. In addition, many states require attendance at regular "monitoring meetings" (i.e., weekly, monthly, or quarterly) for PHP participants, which are generally facilitated by a mental health professional, but are focused less on psychotherapeutic intervention and more on education and ensuring compliance with PHP contract components. During this extended period, any evidence of substance use or other non-compliance usually stops medical practice for re-evaluation, further treatment, and/or subsequent increased frequency of testing. Compliance with the PHP contract is typically required by state licensing boards for continued licensure. However, it is important to note that PHPs do not directly provide treatment; instead, they manage physician care through referral, overseeing participation in high-quality treatment, and monitoring. PHP participation has demonstrated efficacy (DuPont, McLellan, White, Merlo, & Gold, 2009; McLellan, Skipper, Campbell, & DuPont, 2008), but little is known about its relative efficacy among the subpopulation of physicians with opioid use disorders. In the current study, treatment outcome was compared among physicians diagnosed with substance dependence who had a history of alcohol use only, any opioid use, or non-opioid drug use, in order to determine whether ABPT with long-term care management without OST can be as effective for individuals with opioid use disorders (OUDs) as for those with alcohol or other drug use disorders.

2. Method

2.1. Procedure

The study employed a minimum 5-year, retrospective chart review, intent-to-treat analysis of all physician participants admitted to 16 PHPs participating in a national survey evaluation. Under their PHP contracts, physicians were required to maintain complete abstinence from addictive substances, including alcohol and other prescription or over-the-counter mood-altering medications [e.g., diphenhydramine (Benadryl), cough syrups, sleep aids]. Exceptions were made for prescription medications that were approved by the PHP based on adequate documentation of medical necessity. In most cases, however, opioid agonist medication was not allowed due to PHP policy. Physicians were monitored through frequent random testing with a panel of about 20 drugs, including alcohol biomarkers (most often ethyl glucuronide and ethyl sulfate). Those physicians consecutively admitted to the PHPs from September 1, 1995 through September 1, 2001 were followed through inspection of laboratory results, review of PHP charts (including evaluations, progress reports from treating providers, and feedback from workplace monitors), and examination of their employment records (e.g., status of medical license, status of medical practice (full-time, part-time, licensed but not in practice, etc.), restriction of DEA license, etc.) for the ensuing 5 years or longer. [For more details on the participating PHPs, data collection procedure, demographics of the full physician sample and outcome results see DuPont et al., 2009; McLellan et al., 2008; DuPont et al., 2009; Skipper, Campbell, & DuPont, 2009; White, DuPont, & Skipper, 2007; Skipper & DuPont, 2011.]